



STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
Crime Victims Compensation Program  
*PO Box 44520 • Olympia, Washington 98504-4520*

Dear Provider:

Attached is the Provider Application and Agreement (form) necessary for obtaining a provider account number with the Washington State Department of Labor and Industries Crime Victims Compensation Program (CVC). For group practices, each provider who will be providing services to CVC clients must complete and sign a Provider Application and Agreement.

CVC will only purchase covered services, provided by covered professionals. Coverage information is contained in the Washington State "Medical Aid Rules and Fee Schedules or the "Crime Victims Compensation Program Mental Health Treatment Rules and Fees".

A completed Form W-9 is required as part of the application process to ensure proper reporting to the Internal Revenue Service (IRS). We have enclosed a blank Form W-9 for your convenience. **If you have questions on the Form W-9, please contact the IRS or your tax consultant.**

Please carefully complete the Provider Application/Agreement using the attached instructions.

**An incomplete application will not be processed.** Please be sure to:

- 1) Complete the application and sign the Provider Agreement.
- 2) Submit your completed Form W-9.
- 3) Submit a copy of your professional license, certification or registration, if you are required to be licensed, certified or registered by your state's professional health care licensing authority. Master level counselors must include a copy of their academic degree.

Once a provider account number has been established, you will receive information regarding rules, fees, billing instructions and forms, or if you have questions about the application, please call the Provider Registration desk at (360) 902-5377.

Sincerely,

Provider Registration

## **INSTRUCTIONS**

### **NOTICE:**

**Each individual provider must complete Section II.B. of the application.**

If additional copies are needed, call (360) 902-5377, or copy all portions of the application..

### **SECTION I TO BE COMPLETED BY ALL PROVIDERS**

Enter the Tax Payer Identification Number (EIN or SSN). **The number you will use to report earnings to the IRS - This must match the information on the W-9.**

### **SECTION II: TO BE COMPLETED BY ALL PROVIDERS**

#### **A. Administrative Information**

1. Enter the name of the business you wish to submit your bills and have your account set up as, (DBA).
2. Enter the phone number of the business.
3. Enter the billing address as it appears on your bills submitted to Crime Victims Compensation Program and where payments should be mailed.
4. Enter the physical address of the business.
- 5a. Enter the name of the contact person to call to ask questions regarding your bills or your account..
- 5b. Enter the billing phone number where we may call to ask questions regarding your bills or your account, if necessary.

#### **B. Individual Provider Information** –Complete this only if you are a health care provider.

1. Enter the name of the person providing services to crime victims clients.
2. Enter the type of service(s) provided..
3. Enter the type of professional license, certification or registration (i.e., Physician, Chiropractor, LMP).
4. Enter your license, certification or registration number.
5. Enter the date the license, certification or registration was issued (month, day and year). **ATTACH COPY**
6. Enter the date the license, certification or registration will expire (month, day and year).
7. Enter the state where the license, certification or registration was issued.
8. Enter your Drug Enforcement Agency (DEA) number.
9. Enter your Social Security Number (for identification only).
10. Check whether you are board certified. **Include a copy of certification**
11. Enter any current Crime Victims Compensation Program Provider Account Number(s) that you may have.
12. Enter whether you wish to keep the account number(s) active and if so, which one(s).

#### **C. Physician Assistants Section**

1. Enter the name of the supervising physician. If practicing under more than one supervising physician, see instruction #8 below.
2. Enter the supervising physician's specialty.
3. Enter your supervising physician's Social Security Number (for identification only).
4. Enter the supervising physician's professional **license** number, the state license was issued and the date license expires..
5. Supervising physician Board certified? If checking yes, **include a copy**.
6. Enter supervising physician's Crime Victims Compensation Program Provider Account Number.
7. Enter the supervising physician's Drug Enforcement Agency number.
8. Physician assistants with more than one supervising physician must submit the information contained in Section C on a separate sheet of paper for each physician or employer for whom they work.
9. Submit a Provider Application/Agreement for each tax I.D under which you will bill for treating CVC clients.

**\* Each January the Internal Revenue Service requires us to send a completed Form 1099 MISC reporting payments of \$600.00 or more made to a Federal Tax Identification Number (EIN or SSN) during the last calendar year. If you received payments from more than one department program, you may receive more than one Form 1099 Misc.**

***PLEASE DO NOT FORGET TO READ THE "PROVIDER APPLICATION AND AGREEMENT" AND SIGN THE APPLICATION AS INDICATED AT THE END OF THE AGREEMENT.***

# PROVIDER ACCOUNT APPLICATION

## Return To:

Department of Labor and Industries  
Crime Victims Compensation Program  
Provider Registration  
PO Box 44520  
Olympia WA 98504-4520

(Please type or print clearly on all sections)

Please  
check:

☐

New

☐

Update

☐

Tax ID change – Effective Date \_\_\_\_\_

Required

(360) 902-5377

Internet address: <http://www.Lni.wa.gov/forms>

## I. TAX REPORTING INFORMATION

Tax Payer Identification Number (EIN or SSN)

**THIS NUMBER MUST MATCH THE W-9 FORM YOU SUBMIT**

*If you are a medical practitioner, or a mental health provider, you must also complete Section II.B.*

*Unless otherwise notified, your claims related correspondence will go to your business (physical) address.*

## II. ACCOUNT AND BILLING INFORMATION

### A. Administrative Information

1. Business name (as you wish to submit your bills and have your account set up, DBA)	2. Business phone#	2a. Business FAX#
3. Billing address (as it appears on your bills submitted to CVC and where payments should be mailed)	4. Business address (the physical location of the business)	
5a. Contact person	5b. Billing phone# (where we may call regarding your account/bills)	

### B. Individual Health Care Provider Information

Attach copy of current license

If adding to a group, put  
group number here

1. Provider's name (last, first, MI)	2. Specialty	
3. Type of license/certification/registration (i.e., physician, chiropractor, LMP) ATTACH CURRENT COPY	4. Professional license/ certification/registration number	
5. License issue date: (month – day – year)	6. License expiration date: (month – day – year)	7. Issued in which state?

8. DEA (narcotic) number	9. Social Security Number (for I.D. only)	10. Board certified? If Yes include copy <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Current CVC Provider Account Number(s)	12. Do you wish them to remain active? If Yes, which one(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### C. Physician Assistants fill out this section regarding your supervising physician in addition to the above.

1. Supervising Physician's name (last, first, MI)	2. Specialty	
3. Social Security Number (for ID only)	4. Professional license number/state issued/expiration date	
5. Board certified? If Yes, include copy. <input type="checkbox"/> Yes <input type="checkbox"/> No	6. CVC Provider Number(s)	7. DEA (narcotic) number

#### D. Other Administrative Information

1. Check the appropriate type of service that you will be performing or if one is not listed, please specify under "Other".
2. Enter practice specialty, sub-specialty (if applicable), and the type of certificates or national accrediting bodies you receive recognition from based on your professional license.
3. Enter any current Crime Victims Compensation Program Provider Account Number(s) that you may have.
4. Enter whether you wish the account number(s) to remain active and if so, which one(s).

##### 1. Type of service **(PLEASE CHECK ONE):**

<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Home Health Agency	<input type="checkbox"/> Physical Therapist
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Hospital	<input type="checkbox"/> Physician **
<input type="checkbox"/> ARNP	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Attendant Care	<input type="checkbox"/> Hospital Psychiatric	<input type="checkbox"/> Prosthetist/Orthotist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Interpreter <b>(Must have attestation sheet)</b>	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Clinic		<input type="checkbox"/> Radiologist
<input type="checkbox"/> CRNA	<input type="checkbox"/> IV Therapy	<input type="checkbox"/> Rehab Training Facility
<input type="checkbox"/> Day Care Provider	<input type="checkbox"/> Lab Facility	<input type="checkbox"/> Rehab Training Supplier
<input type="checkbox"/> Dentist	<input type="checkbox"/> LMP	<input type="checkbox"/> Residential Treatment Facility
<input type="checkbox"/> Denturist	<input type="checkbox"/> Mental Health ****	<input type="checkbox"/> School <b>(Include license, i.e., business, accreditation)</b>
<input type="checkbox"/> DME Supplier	<input type="checkbox"/> Naturopathic Physician	<input type="checkbox"/> Sexual Assault Center
<input type="checkbox"/> Drug & Alcohol Treatment	<input type="checkbox"/> Nurse Case Management	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Ferry	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Speech Pathologist
<input type="checkbox"/> First Surgical Assist (RNFA) *	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Vocational Services
<input type="checkbox"/> Free Standing Emergency Room	<input type="checkbox"/> Optician	<input type="checkbox"/> Vocational Counselor
<input type="checkbox"/> Free Standing Ambulatory Surgical Care <b>(Medicare letter required)</b>	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Vocational Specialist
<input type="checkbox"/> Head Injury Program ***	<input type="checkbox"/> Osteopathic Physician **	<input type="checkbox"/> Job mod/pre-job mod supplier
<input type="checkbox"/> Hearing Center	<input type="checkbox"/> Pain Clinic ***	<input type="checkbox"/> Job mod/pre-job mod consultant
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Panel Exam Group	<input type="checkbox"/> Retraining
<input type="checkbox"/> Fitter/Dispenser	<input type="checkbox"/> Pharmacy <b>Copy of DEA permit and pharmacy license required)</b>	<input type="checkbox"/> Work Hardening
<input type="checkbox"/> Other: (specify) _____		

##### 2. Specialty in above field

Sub-Specialty

State/National accreditation(s) and certifications

##### 3. Current L&I Provider Account Number(s) – (omit if you are completing Section II.B)

##### 4. Do you wish to have the above account(s) remain active? If Yes, which one(s)?

☐

Yes

☐

No

\* Must include a copy of privilege letter with each facility

\*\* Physical medicine must include copy of board certification or documentation of eligibility.

\*\*\* Must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)

\*\*\*\* Mental health counselors must have a masters degree in a field of study related to mental health services including, but not limited to, social work, marriage and family therapy or mental health counseling.

## PROVIDER APPLICATION & AGREEMENT

The Crime Victims Compensation Program (CVC) is authorized by Washington State law, Title 7, Chapter 68, Revised Code of Washington (RCW), and is administered by the Department of Labor and Industries. Health care and other services are provided to CVC clients pursuant to Title 7, Chapter 68 RCW, Washington Administrative Code (WAC) Chapters 296-30, and 296-31, and policies adopted by the department, including medical coverage decisions. **To qualify for payment, a provider must have an active provider account number assigned by CVC.** To receive a provider account number, the provider must submit a CVC Provider Application to CVC, including all required supporting information and a signed "Provider Agreement." For group practices, a separate Provider Application/Agreement is required for each provider who will be providing services to CVC clients.

**The following information must be submitted with the Provider Application, a:**

- **current copy of the provider's current professional license, certification or registration. Master level counselors must include a copy of academic degree;**
- **signed and dated Provider Agreement;**
- **completed Form W-9.**

A provider's account number will become inactive if CVC does not receive any bills from the provider for a consecutive **36-month period**. If the provider's account becomes **inactive**, the provider must **reactivate the account** prior to submitting bills by calling the CVC Provider Registration Section at 360-902-5377. A new Form W-9 is needed to reactivate an account, **only** if information on that form has changed.. Providers with inactive accounts will not automatically receive department publications, such as Provider Bulletins, Provider Updates, rules or fee schedules. **Issuance of a provider number does not guarantee that all services billed by a provider will be paid by CVC. Payments will be made according to the department's "Medical Aid Rules and Fee Schedules", or the "Crime Victims Compensation Program Mental Health Treatment Rules and Fees" as updated annually and according to department policy. The department will purchase only covered services, provided by covered professionals.**

**The provider agrees:**

1. To meet and maintain all applicable state and/or federal licensing, certification or registration requirements to assure the department of the provider's qualifications to perform services.
2. To comply with Washington State Law Title 7, Chapter 68 RCW, and WACs, including but not limited to, Chapters 296-30, and 296-31, and policies adopted by the department, including fee schedules and medical coverage decisions.
3. That providing services to or filing an application for benefits on behalf of a crime victim who is covered under the department's jurisdiction, constitutes acceptance of the requirements of Title 7, Chapter 68 RCW, and WACs, including but not limited to, Chapters 296-30, and 296-31, and policies adopted by the department, including fee schedules and medical coverage decisions.
4. To bill CVC the provider's **usual and customary** charges for services rendered to CVC clients as required by Washington State law.
5. To bill primary or public insurance prior to billing CVC.
6. To accept the department's payment after primary or public insurance has been billed as complete remuneration for services provided to the CVC client as required by Washington State law. **The provider agrees not to bill a CVC client for:**
  - a) services covered by CVC which are related to the crime victim's claim.
  - b) the difference between the billed and paid charges; or
  - c) the difference between the provider's customary fee and the department's fee schedule.

In the event a provider believes additional funds are due, the provider may submit a Provider's Request for Adjustment Form to the department for consideration in accordance with the instructions contained on the Remittance Advice.

7. That if the provider receives payment from the department in error or in excess of the amount properly due under the applicable rules and procedures the provider will promptly return to the department any excess monies received. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided in Washington State law.
8. To maintain documentation and records for a minimum of five years to support the services and levels of services billed. The provider agrees that these records and supportive materials will be made available to the department upon request as provided in Washington State law.
9. To notify CVC immediately of any changes to information in this application or provider status (e.g., federal tax identification number, ownership, incorporation, address, etc.). **A change in ownership or federal tax ID number may require a new provider account number**

A provider will be held to all the terms of this agreement even though a third party may be involved in billing claims to the department. The department reserves the right to deny, revoke, suspend or condition a provider's authorization to treat CVC clients in accordance with Washington law.

### Provider's Statement of Agreement

I (the provider), \_\_\_\_\_, (print or type) agree to abide by the terms of this agreement and by all applicable federal and Washington State statutes, rules and policies. I have enclosed with my application all required supporting information to establish a provider account, including: a current copy of my current license, certification or registration (if I am required to be licensed, certified or registered by my state licensing authority); and a completed Form W-9.

Date	Title	Signature
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